NEW DIABETES EDUCATION PATIENT INFORMATION

Patient Name:		ate of Birth:				
Age @ Diagnosis:	New diagnosis: Y/N	New diagnosis: Y/N Type 1/Type 2/Don't know or not sure				
Blood Glucose testing and Diabetes questionnaire						
Are you currently testing your blood glucose? Yes No	If Yes, how often and what time of day do you test?	of day do What type of glucometer do you use?				
Do you have hypoglycemia episo	Yes No					
Do you carry food to treat hypogl						
Do you wear a medical ID?						
Have you required assistance fro	m others to treat your lows?					
Do you have a glucagon emerge	ncy kit?					
Do you always check your blood sugar before you drive?						
Have you ever had a low blood sugar while driving?						
	Do you have a sick day plan and/or disaster plan for your diabetes supplies?					
Do you have ketone test strips at	home?					
Have you had any hyperglycemic (high blood sugars) episodes in the past 2-3 weeks?						
Have you had any hospital/ER visits in the past 3 months for high or low blood sugars?						
What was your last A1C?						
	Social/Lifestyle/Quality of Life					
Are you pregnant or plan to become pregnant? ☐ Yes ☐ No ☐ Do you smoke? ☐ Yes ☐ No						
Employment factors you have that might impact your diabetes self-care (Check all that apply) □ Variable/Rotating Shifts □ Sedentary job Can you describe what diabetes is: □ Unpredictable Meal Breaks/□ Nowhere to keep diabetes physical activity testing/medication supplies □ Unsupportive supervisor □ Other:						
Other factors that might impact your diabetes self-care						
 None Relationship conflicts or la support Hectic schedule Cultural/Religion practice 	□ Lack of Motivation □ Cack of □ Other health issues □ Financial Concerns □ Depression/Anxiety □	Diabetes Burnout Diabetes Regimen too complicated Confusion about my diabetes regimen Lack of knowledge Other:				

Patient Identification - Write in or attach patient label

Name: MRN #:

CSN#:

DOB/Sex:





Have you had instructions on managing your diabetes or diabetes education in the past? No Yes/Location	How confident are you in managing your diabetes on a scale from 1 (not confident) to 10 (totally confident)? Why:
	How do you like to learn new things?
Any hearing, eyesight, reading issues or	(check all that apply)
language barriers that impact your learning	□ Reading
□ Yes □ No	□ Lectures/Classes
Please	Using the Internet
explain:	 Watching Videos/ TV
	Individual / demonstrations

Nutrition, Activity, and Medical History						
Current Height: Current Weight:	Weight changes in the past year?					
What food planning methods have you followed in □ Calorie counting □ No added sugar □ Carbohydrate Counting □ Low Carb □ Low Fat □ South Beach □ Exchange Lists □ Low Sodium	□ Weight Watchers □ Paleo					
What method of food planning are you using now?	How many times per week do you eat out? (including beverages) □ 0 □ 1-2 □ 3-4 □ >4 Do you cook your own meals? □ Yes □ No Please explain:					
What times of day do you typically eat? Breakfast: Lunch: Dinner:						
What kind of foods do you typically choose as snack foods?						
How often do you drink juice? How often do	o you drink Regular Soda? How often do you drink					
	or more a day Alcohol?					
□ Few times a week □ Few ti						
	than once a week					
□ Never □ Never	r					
Do you have any other						
Do you get deliberate and Pes No regular exercise?	How often and what type?					

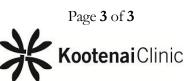
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patient label Name: MRN #: CSN #: DOB/Sex:





Do you take any diabetes medications?	□Yes	□ No	Please list name(s) and dose(s):
Do you have any concerns about your Diabetes medications?	□Yes	□No	If Yes please explain:
What is your preferred Pharmacy?		cy?	What would you like to learn about today or what changes would you like to make?
Location and date of last eye exam:			
Are you legally blind or have cataracts:		ts:	
☐ Yes:	□	No	What concerns you most about having Diabetes:
Date of last dental exam:			
Date of last foot exam:			





DOB/Sex: